Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KUNJEELAL CHANDRAKAR, MD
PO BOX 741865
DALLAS, TEXAS 75374

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-1576-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS" and "REQUIRED TESTING REQUESTED BY DD"

Amount in Dispute: $775.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of dispute was placed in carrier rep box on January 28, 2011 with no response to MFDR.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2010	99456-RE-W6, 99456-RE-W7, and 95851	$775.17	$775.17

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes: Explanation of Benefits-NA

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. There are no EOBs, response to request for reconsideration, nor response to MFDR regarding denial of disputed services. The Division will proceed with this review per applicable fee guidelines.
2. The requestor (DD) billed $500.00 for CPT code 99456-RE-W6 for an Extent of Injury (EXT) determination. The requestor also billed $250.00 for CPT Code 99456-RE-W7 to determine whether the injury was a Direct Result of the work related incident (DIR). Review of documentation supports that the Division ordered the examinations. Per 28 Texas Administrative Code §134.204(i)(2)(A) & (k), the Maximum Allowable Reimbursement (MAR) for the 1st Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examinations is $500.00. Per 28 Texas Administrative Code §134.204(i)(2)(B) & (k), the reimbursement for the 2nd RTW/EMC examination is 50% of MAR which is $250.00. The combined MAR for the EXT and DIR examinations is $750.00. Review of the documentation supports that range of motion (ROM) testing was performed to the spine and the requestor billed $45.00 for CPT code 95851. Per 28 Texas Administrative Code §134.204(k), testing shall be billed using the appropriate CPT codes & reimbursed in addition to the examination. Per 28 Texas Administrative Code §134.203(c), the MAR for 1 unit of CPT code 95851 is $25.22 in zip code 77027 for Houston, (Harris County). The MAR for all services billed is $775.22, the respondent paid $0.00. Reimbursement in the amount of $775.17 is therefore recommended.

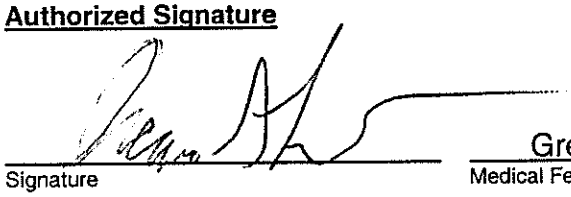
Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $775.17.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $775.17 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature



Signature

Gregory Fournerat
Medical Fee Dispute Resolution Officer

November 4, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.